

Application Form Patient and Family Advisor

OSMH Patient and Family Advisory Council (PFAC)

Please send completed application form via one of the following methods:

Email: patientcareservices@osmh.on.ca

Fax: (705) 325-7394

Mail: OSMH, 170 Colborne Street West, Orillia, ON, L3V 2Z3

Drop-off: Information Desk in Main Lobby of OSMH

Personal Information:

Name:			
Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Age:	<input type="checkbox"/> 18 – 30 <input type="checkbox"/> 30 - 50 <input type="checkbox"/> 50 – 65 <input type="checkbox"/> 65 – 75 <input type="checkbox"/> Over 75
Occupation:	Education:		<input type="checkbox"/> High school <input type="checkbox"/> College <input type="checkbox"/> University <input type="checkbox"/> Post-graduate

Contact Information:

Address			
City:		Postal Code:	
Telephone:		Cellphone:	
Email:			

Preferred Method of Contact:

Telephone
 Cellphone
 Email

Are you a:

Patient (within past 3 yrs.)
 Family Member of a Patient (within past 3 yrs.)

Can you speak and read English?

- Yes No

Other language(s) you speak: _____

The care provided at OSMH was primarily as: (Check all the apply)

- Admitted Patient Emergency Department Patient
 Clinic/Outpatient Other _____

Within the last 3 years, what services have you (or your family member) used? (Check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Urology | <input type="checkbox"/> Respiratory |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Cardiac | <input type="checkbox"/> Mental Health |
| <input type="checkbox"/> Intensive Care | <input type="checkbox"/> Pregnancy, Childbirth, Infant care |
| <input type="checkbox"/> Medicine | <input type="checkbox"/> Child & Adolescent Care |
| <input type="checkbox"/> Endocrinology/Diabetes | <input type="checkbox"/> Other (Please indicate): _____ |
| <input type="checkbox"/> Renal/Kidney | |

Would you be comfortable sharing your experience with the Council in order to make improvements?

- Yes No

Why would you like to serve as an OSMH PFAC member?

What are some issues of special interest to you?

Do you have any talents, gifts or skills that would be advantageous to the OSMH PFAC?

Please specify the time when you are able to attend meetings:

- Daytime Evening
 In person Teleconference

I would be interested in helping with: (you may check more than one box)

- Reviewing patient and family satisfaction survey results
 Developing/Reviewing patient/family educational materials and website resources
 Planning for the out-patient experience
 Planning for the in-patient experience
 Planning for the emergency care experience
 Planning for hospital projects (space, directions, signage)
 Ensuring patient safety and the prevention of medical errors
 Educating students staff, physicians and volunteers about the experience of care
 Improving the coordination of care, discharge planning and the transition to home and community care
 Developing the uses for information technology, including electronic medical records

Are you currently a volunteer at OSMH?

- No Yes

Have you ever been convicted of a criminal offence for which a pardon has not been granted?

- No Yes (please provide details)

- I understand that, upon acceptance into an advisory position, OSMH requires that I submit the results of a criminal reference check (CRC) with the vulnerable sector search (18+ years old). More details are provided at the acceptance stage.

Are you currently or have you ever been involved in a legal challenge between you/your family and a hospital?

- No Yes (please provide details)

- I understand that submitting this application and/or being interviewed does not guarantee a position as a Patient & Family Advisor.

- I understand that prior to beginning as an advisor I must sign a Confidentiality Agreement and Code of Conduct pledge.

- I understand that as an advisor I will be accountable to OSMH and the Patient & Family Advisory Council.

I declare the above information to be true and complete to the best of my knowledge. I understand that a false statement may disqualify me or lead to my dismissal.

SIGNATURE: _____

DATE: _____